

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
10474 CERTIFICATE OF DEATH 10467

1. PLACE OF DEATH a. COUNTY <b>Queen Annes</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Queen Annes</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Crumpton</b>		c. LENGTH OF STAY IN 1b <b>17.1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <b>FRANK J. CONVER</b>		4. DATE OF DEATH Month Day Year <b>July 22, 1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 15, 1888</b>
9. AGE (in years last birthday) <b>77 yrs.</b>		10. FUNOER 1 YEAR <input type="checkbox"/> FUNOER 24 HRS. <input type="checkbox"/> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Phila. Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Conver.</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>211-16-3930A</b>	
17. INFORMANT <b>Mrs. Sara E. Conver,</b>		Address <b>Millington, Md. R.D. Box 56</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>MYOCARDIAL DECOMPENSATION</b> DUE TO (c) <b>C PULMONARY EDEMA</b>		INTERVAL BETWEEN ONSET AND DEATH <b>YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>MAY</b> , 1964, to <b>July</b> , 1966, that (I) (we) last saw the deceased alive on <b>7 July</b> 1966, and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Harry P. Ross</b>		22b. DATE SIGNED <b>7-22-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Harry P. Ross, M.D.</b>		22d. ADDRESS <b>Chestertown, Md. 21620</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 25, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Crumpton Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Crumpton, Q.A.Co; Md.</b>	
24. FUNERAL DIRECTOR <b>Edward Fellows, Millington, Md.</b>		25a. REC'D BY REGISTRAR <b>DATE JUL 26 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

10563

Queen Anne's

Grampian, Royal

Grampian

Grampian

Sept. 15, 1955

Male

W. 1/2, 26.

Grampian

Grampian

Joseph Conner

B. 1/2, 26

211-16-3830A Mrs. Mrs. E. Conner, Wilmington, Del.

No.

Grampian, No. 21630

Henry T. Conner, N.D.

Grampian Cemetery

July 15, 1955

Grampian

10563

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
10475 CERTIFICATE OF DEATH 10468

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNES</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CHESTER</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CHESTER</u>	
c. LENGTH OF STAY IN 1b <u>AL HER L.F.E</u>		d. STREET ADDRESS <u>17-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY ELIZABETH KERSEY</u>		4. DATE OF DEATH Month Day Year <u>JULY 2 1966</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 6, 1877</u> 88 yrs.
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Stevensville, D.C., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HENRY COLLIER</u>		14. MOTHER'S MAIDEN NAME <u>Emily Catherine Porter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-20-5814-T</u>	
17. INFORMANT <u>Mrs. Thomas R. Price, Chester, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>chronic menia</u> <u>442X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>nephro-sclerosis</u> DUE TO (c) <u>hypertensive arteriosclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>about 2 years</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Carcinoma left breast removed 13 years ago medical treatment</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>1 year</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 10, 1953</u> to <u>July 2<sup>nd</sup></u> , 1966, that (I) (we) last saw the deceased alive on <u>July 2</u> , 1966, and that death occurred at <u>7:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Theodor Sattelmaier</u> M.O.		22b. DATE SIGNED <u>July 3, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>THEODOR SATTELMAIER</u>		22d. ADDRESS <u>STEVENSVILLE, MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>July 2, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>STEVENSVILLE CEMETERY</u>	23d. LOCATION (City, town or county) (State) <u>STEVENSVILLE, MARYLAND</u>
24. FUNERAL DIRECTOR <u>James H. Butler Jr., Butler Bros., Stevensville, Md.</u>		25a. REPORT BY REGISTRAR <u>DATE JUL 6 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

County of Dallas  
City of Dallas  
State of Texas

Myself, Elizabeth K. Jones  
County of Dallas  
City of Dallas  
State of Texas

Myself, Elizabeth K. Jones  
County of Dallas  
City of Dallas  
State of Texas

Myself, Elizabeth K. Jones  
County of Dallas  
City of Dallas  
State of Texas

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<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>									
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Queen Annes</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Millington</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Near Massey</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) <b>Serge</b> <sup>First</sup> <b>Sergie</b> <sup>Middle</sup> <b>Tkach</b> <sup>Last</sup>					<b>4. DATE OF DEATH</b> <b>July 4, 1966</b>				
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Sept. 24, 1895</b>		<b>9. AGE</b> (In years last birthday) <b>70</b> yrs.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farm Labor</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farming.</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Russia</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>1 st. Papers</b>		<b>13. FATHER'S NAME</b> <b>Unknown</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>unknown</b>		<b>16. SOCIAL SECURITY NO.</b> <b>215-20-4704A</b>		<b>17. INFORMANT</b> <b>Charles Mason</b>		<b>Address</b> <b>1740 Fleet St; Balt. Md.</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <b>Cerebral Hypoxia</b> <b>4221</b> DUE TO (b) <b>Chronic Tissue Necrosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Pneumonia</b> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE PERMANENT DISEASE CONDITION GIVEN IN PART I(a)</b> <b>Smile</b>									<b>INTERVAL BETWEEN ONSET AND DEATH</b>
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.) <b>240</b>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>June 2, 1966</b> <b>to</b> <b>July 4, 1966</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>June 2, 1966</b> , <b>and that death occurred at</b> <b>8 PM</b> , <b>from the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <i>C.H. Metcalfe</i>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>7/5/1966</b>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>C.H. Metcalfe, M.D.</b>				<b>22d. ADDRESS</b> <b>Sudlersville, Md. 21668</b>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>July 7, 1966</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Holy Trinity Orthodox Cem.</b>		<b>23d. LOCATION (City, town or county)</b> <b>Elkridge,</b>		<b>(State)</b> <b>Md.</b>	
<b>24. FUNERAL DIRECTOR</b> <b>Edward Fellows</b>				<b>ADDRESS</b> <b>Millington, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>Charles Judge</b>		<b>25b. REGISTRAR'S SIGNATURE</b>	

10078

Green House

Millington

West Hester

Kent

George

Tracy

Tracy

Sept. 24, 1906 70

x

White

Part Labor

Part Labor

Part Labor

Unknown

Unknown

218-20-47044 Charles Mason, 1740 First St; Baltimore, Md.

*Handwritten signature*

*Handwritten signature*

*Handwritten signature*

*Handwritten signature*

*Handwritten signature*

Philadelphia, Pa. 1910

Philadelphia, Pa. 1910

July 7, 1906 Holy Trinity Church on Oak Street

July 7, 1906

*Handwritten signature*



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Queen Anne's</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Queen Anne's</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sudlersville</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sudlersville</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LIDA KENNY WALLEN</b>			First Middle Last		4. DATE OF DEATH <b>July 31, 19 66</b>		Month Day Year		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>		8. DATE OF BIRTH <b>May 30, 1880</b>		9. AGE (In years last birthday) <b>86</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard M. Leager</b>					14. MOTHER'S MAIDEN NAME <b>Annie Scotten</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>			16. SOCIAL SECURITY NO. <b>214-03-5002</b>		17. INFORMANT <b>Mrs. Rena Coleman, Sudlersville, Md. 21668</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Dilatation</b> <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic myocarditis</b> DUE TO (c) <b>General Cardiac Sclerosis</b> <b>known</b>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19 66</b>			20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>July 29, 1966</b> to <b>July 31, 1966</b> that (I) (we) last saw the deceased alive on <b>July 31, 1966</b> and that death occurred at <b>10:00</b> M, from the causes and on the date stated above.								22b. DATE SIGNED <b>8/1/66</b>	
22a. SIGNATURE <b>C.H. Metcalfe, M.D.</b>			22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>Sudlersville, Md. 21668</b>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Aug. 3, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Millington Cemetery.</b>		23d. LOCATION (City, town or county) (State) <b>Millington, Kent Co; Md.</b>		
24. FUNERAL DIRECTOR <b>Edward Fellows, Millington, Md.</b>			ADDRESS		25a. REC'D BY REGISTRAR <b>AUG 3 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

2. *Other* (10%)

1000

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Yong, L., & Smith, J. (2001).

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